STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	**1001 SW 29TH ST TOPEKA, KS 66611**

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F 000	INITIAL COMMENTS The following citation represent the findings of complaint investigation #80145.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 90 residents with 3 residents sampled for accidents. Based on observation, interview, and record review, the facility failed to provide supervision as care planned to resident #1 to prevent a fall that resulted in a fractured leg, and failed to follow through with the care plan intervention implemented for resident #2 after a fall. Findings included: - The undated electronic face sheet recorded resident #1 with diagnoses that included muscle weakness and abnormal gait. The annual Minimum Data Set (MDS) Assessment dated 6/23/14 documented the resident with a BIMS (Brief Interview for Mental Status) score of 13, which indicated intact cognition. The resident wore glasses for impaired vision, required extensive assistance with bed mobility, and limited staff assistance with transfers, dressing, toilet use, and personal hygiene. The resident had impaired balance, was	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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only able to stabilize with staff assistance, used a wheelchair or walker for mobility, and experienced a non-injury fall since the last assessment.

The Care Area Assessment for falls dated 7/1/14 documented on 5/24/14 the resident stood up to transfer him/herself and fell.

Review of the quarterly MDS dated 9/8/14 recorded the resident with a BIMS score of 14, which indicated intact cognition, and no longer used a walker for mobility.

Review of the Fall Assessment dated 4/21/14 recorded a total score of 25, which indicated the resident was a high risk for falls.

The plan of care for falls dated 7/1/14 recorded risk factors related to weakness and vertebroplasty (a procedure where special bone cement was injected directly into a fractured bone of the spinal column to relieve pain). The care plan directed staff to keep the call light within reach, room clutter-free, well lit, and with a night light on. Intervention added on 2/28/14 directed staff to stay with resident in the bathroom (not to be left alone in the bathroom) provide verbal reminders to call for help when getting out of a low bed, and supervise ambulation.

Nursing note dated 10/8/14 timed 1:50 P.M., recorded at 9:20 A.M., staff heard the resident yelling for help and found the resident lying on his/her left side in the bathroom with his/her head facing the bedroom hallway. The resident had a small laceration to his/her left scalp with bruising around area. The resident ' s left leg faced outward and appeared significantly shorter than right leg. Three staff members assisted the

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resident to a supine (lying on the back) position in bed and called for a portable x-ray of the resident ' s left hip.

Nursing note dated 10/8/14 timed 1:54 P.M. recorded at 10:30 A.M., a mobile x-ray arrived at the facility and obtained a pelvic (bones that connect the base of the spine to the supper end of the rear legs) x-ray.

Nursing note dated 10/8/14 timed 1:55 P.M. documented at 12:00 P.M. the facility received a fax that recorded a left hip fracture on the x-ray.

Nursing note dated 10/8/14 timed 2:35 P.M. recorded at 1:40 P.M. the emergency transport transferred the resident to an acute care hospital.

On 11/7/14 at 12:00 P.M. licensed nursing staff I reported he/she observed the resident lying on the floor partially out of the bathroom and his/her left leg was shorter and turned outward.

On 11/7/14 at 12:10 P.M. direct care staff O revealed staff read the resident care plans for care interventions and stayed with the resident while he/she was on the toilet.

On 11/7/14 at 12:17 P.M. direct care staff R reported the resident required extensive assistance from staff with all cares and was weaker and more confused. The resident ' s care plan directed he/she was not to be left alone on the toilet.

On 11/7/14 at 12:30 P.M. interview with direct care staff S revealed the resident called out for help and he/she found the resident lying on the bathroom floor.

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F 323	Continued From page 3 On 11/7/14 at 12:35 P.M. direct care staff P reported he/she transferred the resident to the toilet, told the resident to use the call light when he/she was finished, and left the resident on seated on the toilet without supervision. On 11/7/14 at 12:41 P.M. direct care staff Q revealed staff provided care as directed on the resident care plans and stayed with the resident after he/she transferred to the toilet. On 11/7/14 at 1:05 P.M. licensed nursing staff H reported the resident was weaker and confused during the 3 days prior to his/her fall. Staff should stay with the resident while he/she was on the toilet. On 11/7/14 at 2:00 P.M. administrative nursing staff D stated staff should have stayed with the resident after assisting him/her to the toilet. The facility provided a policy for Fall Prevention and Management Protocol dated 12/1/13 that recorded staff provided optimal communication regarding the elder ' s condition and potential for fall with other care providers. Each team member was responsible for checking the care plan of elders who were at risk for falls when beginning work each day. The facility failed to follow care plan interventions as planned to provide supervision to this resident who experienced a fall that resulted in a left hip fracture and required hospitalization and treatment. - The annual Minimum Data Set (MDS) assessment dated 5/19/14 recorded resident #2 with a Brief Interview for Mental Status (BIMS) score of 3, which revealed the resident had	F 323		

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severe cognitive impairment, required limited assistance from staff for bed mobility, transfers, ambulation, toilet use, dressing, and personal hygiene. His/her balance was not steady but he/she was able to stabilize without staff assistance and used a walker or wheelchair for mobility. The resident experienced one fall with a minor injury fall since the previous assessment.

The care area assessment for falls dated 5/22/14 documented the resident with dementia (progressive mental disorder characterized by failing memory, confusion), impulsiveness, and experienced a fall on 5/3/14, ambulated with a walker independently and staff provided supervision and cueing for ambulation.

The quarterly MDS dated 8/4/14 recorded no change from the resident ' s previous assessment.

The resident ' s care plan dated 8/21/14 identified the resident at risk for falls and revealed staff encouraged the resident to wears shoes or slippers when getting up, supervised ambulation and minimized distractions, and encouraged the resident to use the call light for help. Staff provided the resident assistance to the bathroom a half-hour before meals, kept the night light on the bathroom and tried to keep the room door ajar to check on the resident frequently for safety. Staff encouraged the resident to ask for assistance with toileting and provided reminders to use the walker for ambulation.

A new intervention placed on the resident ' s care plan dated 10/25/14 recorded physical therapy was to evaluate the resident for a recent fall.

A nursing note dated 10/25/14 at 4:18 P.M.

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F 323	Continued From page 5 documented staff found the resident sitting on the floor of his/her room with a 2 centimeter skin tear to the right elbow. Review of the facility investigation revealed on 10/25/14 at approximately 4:00 P.M. staff found the resident on the floor in his/her room and documented a new intervention for a physical therapy evaluation. 11/5/14 at 9:09 A.M. the resident was sitting in the main common area with his/her walker in front of him/her, glasses on, when asked how he/she was doing he/she mumbled .... Observations on 11/7/14 at 7:45 A.M., revealed direct care staff L walked side by side the resident with his/her walker from the living room to the resident ' s room. On 11/7/14 at 1:50 P.M., therapy staff HH walked around the living room with the resident with his/her walker. On 11/7/14 at 8:00 A.M. licensed nursing staff J reported the resident did not receive physical therapy and confirmed the care plan intervention for a physical therapy evaluation on the resident ' s care plan dated 10/25/14. On 11/7/14 at 9 A.M. therapy staff GG reported the staff record all therapy notes in the computer and there were no notes for a therapy screen or therapy treatment for the resident in the computer since January. On 11/7/14 at 10:45 A.M. direct care staff L reported staff provided stand by assistance with ambulation and the resident did not receive physical therapy.	F 323		

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F 323	Continued From page 6 On 11/7/14 at 2:15 P.M. direct care staff M reported the resident recently experienced a fall and required staff supervision and standby assistance. On 11/7/14 at 2:25 P.M. direct care staff N reported the resident required staff supervision with ambulation and in his/her room due to a fall. On 11/7/14 2:45 P.M. administrative nursing staff D reported the physical therapy screen recorded on the resident ' s care plan dated 10/25/14 was not done until today, 11/7/14. The facility provided policy Caring for an Elder that has Fallen, dated 10/11/11 recorded a fall was documented on the care plan with interventions to prevent further falls. The facility failed to provide interventions as planned to prevent falls for this cognitively impaired resident that experienced a recent fall.	F 323		